Agency of Human Services

Practice Guidelines for the Identification and Treatment of Co-occurring Mental Health and Substance Abuse Issues In Children, Youth and Families

The Vermont Practice Guidelines on Co-occurring Mental Health and Substance Abuse Issues in Children, Youth and Families is based on the Comprehensive Continuous Integrated Systems of Care (CCISC) model, which defines the characteristics of a system of care for individuals with co-occurring disorders. This model has been adopted, by the Agency of Human Services as a statewide framework for service system design and implementation.

The principles defined in this document, *welcoming, relationship building, matching, and integrating*, will be the basis for the delivery of treatment services to children, youth and families with co-occurring mental health and substance abuse issues. These principles organize key clinical expectations in the development of integrated, continuous, and comprehensive services for children, youth and families. Each system and program is responsible for generating positive outcomes for children, youth and families with co-occurring mental health and substance abuse issues, in keeping with the core principles outlined here.

This document was created during the spring and summer of 2004 in consultations with over 90 stakeholders including youth and their families, community providers, state policy makers and staff from the Agency of Human Services member departments. Technical feedback and clinical consultation was provided by Drs. Ken Minkoff, Christie Cline, Win Turner and Kim Mueser during several day-long stakeholder sessions and small group working sessions.

Welcoming

Children, youth and families with co-occurring mental health and substance abuse issues are welcomed in every contact, and in every setting.

Standards:

- When taking steps to contact services and supports, children, youth and families are met by caring and competent people
    - Children, youth and families have access to interested and engaged staff and volunteers from their first point of contact forward.
    - Whether the contact is made by phone or in person, staff and community volunteers assure that a direct connection (not just referral) is made for the individual seeking services.
    - Whenever possible, staff, community volunteers, peer support networks and peer counselors are educated about co-occurring mental health and substance abuse issues, and will reach out and provide education in the community.

- Programs provide access to integrated services at times and places that are convenient to children, youth and families.
    - Whenever possible, staff and volunteers are available in places where children, youth and families are found such as schools, courts, and other community-based settings.
    - Whenever possible, programs are open and staffed during some evening and weekend hours.
- Each program has a policy of non-discrimination so that children, youth and families receive services and supports without regard to their race, religion, national origin, gender, sexual orientation, disability, or socio-economic status.

- Welcoming involves cultural and gender sensitivity

- Each program will:
  - Address the needs of children, youth and families of various cultures in ways that elevate their culture;
  - Make every effort to provide access to staff, community volunteers, peers, and/or positive role models that represent the cultural background of children, youth and families.
  - Recognize varying degrees of acculturation and cultural conflict within the family, understanding that perceptions of the majority cultures and minority cultures may differ considerably about "treatment";
  - Incorporate a variety of strategies that build on cultural strengths to engage and retain children, youth and families in treatment.
- Each program or agency has the ability to make accommodations for individuals seeking help (such as ESL, translators, vision and/or hearing impairment, developmental & learning disabilities).
- Staff, including community volunteers, are specifically trained in gender appropriate interventions and have the ability to screen for risk factors that may be present due to gender.
- Children, youth and families have access to gender appropriate services and supports.

Relationship Building

Successful treatment is based on empathic hopeful integrated, continuing and collaborative family, peer, treatment and community relationships.

Standards:

- The integrated service system will support the development and maintenance of a long term continuous clinical *relationship*.
  - Policy and practices will be implemented that support children, youth and families remaining in programs based on their individual needs (i.e. neither relapse nor

improvement will result in removal from or sanctions while in an integrated treatment program).

- Providers will add capacity for additional services when necessary within their agency or through the development of partnerships with other providers.

- Children, youth and families are connected to a caring individual or team that will provide an ongoing integrated assessment as quickly as possible after initial integrated screening indicates that co-occurring issues may be present.

- Youth and families are assured a smooth transition into and through the system of care, including transition into adult life.
  - Children, youth and families have their housing, safety, and sustainability issues adequately addressed.
  - Children and youth in out-of-home placements are provided the supports needed to ensure placement stability with no more than two placements.

- Collaborative treatment team *relationships* and roles are clearly defined through a treatment plan that addresses multiple problems experienced by children, youth and families including co-occurring issues, medical and legal issues, and the complementary services needed to deal with these issues.
  - Youth-centered and family-focused treatment and support can best be delivered through an individual treatment plan developed with youth and family input.
  - The treatment plan must be developed in conjunction with the youth and involve the youth in recognizing and appreciating his/her unique strengths and assets as well as clarifying needs.
  - The treatment plan must include goals with realistic objectives and timeframes for completing them that are mutually agreed upon by the program and the youth.
  - Programs will ensure the basic relationship is maintained until the child, youth or family is ready to respond to the treatment plan.

- Clients and families with more complex needs should have access to enhanced case management support, regardless of setting.
    - The case manager will collaborate with and manage all services as appropriate including healthcare, housing, skills development, education, etc.
    - The case manager must have training and skills in the following areas:
        - An understanding of addiction, and the intergenerational nature of alcohol, tobacco and other drugs abuse;
        - An understanding of mental health issues and associated risk factors;
        - Familiarity with community resources and other youth service systems (education, child welfare, youth justice, mental health, substance abuse, employment services, etc.);
        - Trauma;
        - Family dynamics;
        - Legal issues (informed consent for minors, disclosure of confidential information, child abuse/neglect reporting requirements, and duty-to-warn issues, informing parents)
        - Competency in race, ethnicity, gender, poverty, sexual preference, and other cultural issues.

- Individualized treatment planning and risk management will create an environment in which children, youth and families can achieve the next level of competency in order to attain the next incremental step in autonomy and self-management.
    - Programs commit to implementing evidence-based and/or promising outcome-based treatment strategies that are age appropriate.
    - Programs help children, youth and families to develop support systems that reinforce behavioral gains made during treatment and provide ongoing support to prevent relapse.
        - Peer support programs such as mentoring, anonymous programs, clean and sober community events, and extended family supports are utilized where appropriate.

- Incentives, support, and progressive responses built into empathic, hopeful, and continuous learning *relationships* are an essential component of successful treatment.
- Services and supports are best provided by people who are competent, well trained, and well supported.
    - All clinicians will have licensure or accreditations that indicate their competence with an integrated scope of practice that defines appropriate client and family centered attention to both mental health and substance issues within the context of their licensure, job responsibilities, and programs.
    - Programs will enhance recruitment and retention of professionals qualified specifically to treat youth and families with co-occurring mental health and substance abuse problems.
    - The state and the community provider system will work together to provide initial and ongoing training opportunities for staff, community volunteers, and peer supports in the screening, assessment, and treatment of co-occurring mental health and substance abuse issues.
    - Staff, community volunteers, and peer supports are provided adequate opportunities to receive supervision.

Matching

All individuals with co-occurring disorders are not the same; treatment needs to be matched to individual needs throughout the service system, and interventions must be matched to phases of recovery and stages of change.

Standards:

- Children, youth and families present with many different needs, goals, and learning styles. Interventions and outcomes must be flexible, adaptive, and responsive to *match* with individual needs.
    - For each child, youth and family, the correct intervention and outcome has to be matched to need for integrated relationship, quadrant, diagnoses, level of

impairment, stage of change/phase of recovery, skills for managing issues, availability of contingencies, rehabilitative goals, and level of care.

- Within the context of continuous, integrated, unconditional treatment relationships, children, youth and families can receive a variety of episodic interventions that build on prior treatment progress and are matched to particular needs and stages of change.
- Substance abuse and mental health issues may be chronic relapsing conditions. Therefore, youth and families may be appropriately served by a variety of interventions and supports.

- All children, youth and families presenting for services receive appropriately *matched* integrated screening to facilitate the detection of mental health and substance abuse issues, as well as to facilitate recognition of trauma related issues that may interfere with access to treatment, and may need to be addressed during the course of intervention.

- Assessment is not a single event, but an ongoing process to develop a relationship and to gain insight into the unique abilities, strengths, and needs of children, youth and families in order to *match* services and available resources appropriately.
  - The assessment must identify whether a child, youth or family is in need of treatment, and if so, determine and document the level of severity and recommended placement option for treatment of both the mental health and substance abuse problems.
  - The assessment process must be a collaborative process between the provider and the child, youth and family, and their primary support network.
  - Essential assessment components are:
    - Family history
    - Medical and health history
    - Education history and skill abilities
    - Identification of developmental or learning abilities and disabilities
    - Identification of necessary communication, learning, language, physical or other accommodations

        - Previous treatment history
        - Inventory of assets and strengths
        - Sensitive approach to potential trauma history
        - Collateral information
        - Diagnostic criteria (for substance use and mental health issues)
    - Programs may use one of the identified components of assessment including:
        - ASAM Criteria – 6 dimensions
        - DSM IV criteria based interview
        - Urine test
        - Validated assessment tools for mental health and substance abuse
        - Personalized Feedback Report Form
        - Substance Problem Index/Reasons for quitting
        - Tools for the identification of developmental, cognitive and/or learning disabilities

- Assignment of responsibility for the provision of integrated assessment and ongoing integrated treatment should be defined so that each component of the service system knows which children, youth and families need to be assessed and treated.
    - The continuum of services and systems from prevention through intervention including primary healthcare, child protection, youth justice, mental health, substance abuse, education, runaway and homeless youth service organizations and community-based services must work collaboratively to ensure that children and youth are identified quickly, regardless of the "door" they enter.
    - Children and youth must not be placed in the custody of the state in order to receive services.

- There must be recognition that for children, youth and families, the threshold for problematic substance use may be well below the threshold for addiction, so that services for non-addicted substance using children, youth and families need to be made available.

  - Children and youth whose alcohol, tobacco and other drug use symptoms are severe, but who do not meet the diagnostic criteria may be appropriate for outpatient treatment for further evaluation.
  - If the presenting alcohol, tobacco and other drug history is not adequate to substantiate a diagnosis, the program may use information submitted by collateral parties (family members, legal, guardians, etc.) that indicates a high degree of probability of such a diagnosis.
  - All youth and families should have access to all core services and supports within their local community.

- Treatment planning will ensure that there are no children, youth and families that "fall through the cracks". There will be clear instructions for defining responsibility for children, youth and families at every point in the system.
  - At intake, children, youth and families collaborate on the development of a treatment plan that will define responsibility and coordinate services.
  - Each child, youth, and family will be assigned a primary counselor who will be responsible for the treatment plan and, when needed, a case manager and/or service coordinator.
  - At critical junctures/transition or life events the responsibility and need for coordination will be reassessed.

- Services and supports for youth need to be integrated into the settings where youth are, including mental health settings, substance treatment settings, youth justice, educational and other settings.

- Relapse will be clinically assessed and re-assessed.
  - Children, youth and families must have access to psychiatric evaluation and re-evaluation as needed. More risky behavior requires closer monitoring, not treatment exclusion.

  - Programs must have an established protocol for management of medications that includes the program's policy regarding documentation, storage, supervision, distribution, and administration.
  - Medications will not be routinely withdrawn or reduced because of relapse.

- Programs will adapt services to provide treatment with more support, or a slower pace, in smaller increments, with more practice, rehearsal, or repetition as needed to achieve skill acquisition.
  - Programs must address potential long-term deficits in developmental, psychological, and social growth to help youth make up for the developmental stages that have been compromised due to substance use.

- Each program and system must properly *match* and re-match its services to the needs of children, youth and families, according to these principles.

- A lead service coordinator who will monitor and assure appropriate placement is assigned when needed to help promote success for children, youth and families.

Integrating

Mental health and substance problems are both primary when they co-exist for children, youth and families and integrated primary treatment for each problem is required.

Standards:

- No problem should be underserved because the others are present.
  - Whenever substance use and mental health problems are co-occurring, a youth should receive appropriately intensive, specific treatment simultaneously.

- Programs must address the contributing factors to substance use and mental health issues including sexual abuse, domestic violence, and relationship issues.

  - Children, youth and families need sensitive supports in order to facilitate the identification, evaluation and treatment of violence and trauma.
  - Gender appropriate services and supports must be provided, particularly for those who have been victims of trauma.

- The system of care functions best when there is coordinated and collaborative service delivery among all involved parties.
  - Each child, youth and family will have an integrated treatment plan that combines best practice attention for each mental health problem, each substance problem, each trauma problem, and any criminal justice problem.

- Treatment for each issue, mental health, substance abuse, or trauma, must be provided immediately. No issue will be allowed to "wait" while other issues are being attended.

- *Integrated* assessment should identify stage of change for each problem, and integrated treatment plans should identify stage specific treatment interventions, as well as stage specific outcomes.
  - Effective interventions must be stage specific. Therefore, stage specific assessment is required. The five stages of change (Prochaska & DiClemente, 1992) are pre-contemplation, contemplation, preparation, action, and maintenance. The four stages of treatment (Osher & Kofoed, 1989) are engagement, persuasion, active treatment, and relapse prevention

- For individuals and families in earlier stages of change, motivational enhancement is the appropriate intervention, whether involving individual, family, or group modalities. Individuals, once motivated, receive active treatment, and once stabilized, enter the phase of relapse prevention.

- Rehabilitative goals (relationship, school, and work goals) must be identified early, and may be utilized to promote the recognition of a need for treatment for mental health and/or substance problems.